



# Co-Op Health Plan Opt In

Fall 2017 Application Form

This form will enable you to apply for the FSU Health Plan for the semester by filling in the corresponding application section below. This form must be returned to the FSU Main Office by the **10<sup>th</sup> DAY OF THE START OF CLASSES**

(Fall Semester Coverage is September 1<sup>st</sup> – December 31<sup>st</sup>, 2017)

### STUDENT INFORMATION (PLEASE PRINT CLEARLY)

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Student ID#: \_\_\_\_\_ DOB: d/\_\_\_\_\_ m/\_\_\_\_\_ y/\_\_\_\_\_ Gender: M\_\_\_ F\_\_\_

Campus: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_

**PLEASE ENROLL ME IN THE FOLLOWING:** *(to be eligible, all students must have current OHIP or equivalent coverage)*

**Fall Deadline: September 18<sup>th</sup>, 2017 at 4 p.m.**

**OPT  
IN**

**I wish to apply for:**

**\$ 115.00 HEALTH BENEFITS** (indicate by checkmark) (per semester) (tax included)

**Balanced Plan**  **Enhanced Dental Plan**  **Enhanced Drug/EHC Plan** (indicate by checkmark)

I wish to apply for the Fanshawe Student Union Health Plan and agree to be bound by the benefit plan terms and conditions.

**Payment: CASH, DEBIT and CREDIT to Fanshawe Student Union  
(Return form & money to the FSU Main Office)  
Hours: Monday-Friday, 9:00am-4:30pm**

SIGNATURE OF STUDENT \_\_\_\_\_